

Viral Hepatitis Case Report

Acute Hepatitis C

Michigan Department of Community Health
Communicable Disease Division

Investigation Information									
Investigation ID	Onset Date mm/dd/yyyy	Diagnosis Date mm/dd/yyyy	Referral Date mm/dd/yyyy	Case Entry Date mm/dd/yyyy	Case Completion Date mm/dd/yyyy				
Investigation Status			Case Status <i>Confirmed Not a Case Probable Suspect Unknown</i>						
Patient Status	Patient Status Date mm/dd/yyyy	Part of an outbreak?	Outbreak Name			Case Updated Date mm/dd/yyyy			
Patient Information									
Patient ID	First		Last			Middle			
Street Address									
City		County		State			Zip		
Home Phone ###-###-####		Ext.		Other Phone ###-###-####			Ext.		
Parent/Guardian (required if under 18)									
First		Last			Middle				
Demographics									
Sex <i>Male Female Unknown</i>		Date of Birth mm/dd/yyyy		Age		Age Units <i>Days Months Years</i>			
Race (Check all that apply) <i>Caucasian African American American Indian/Alaska Native Hawaiian/Pacific Islander Asian Unknown Other (Specify) _____</i>									
Hispanic Ethnicity <i>Hispanic/Latino Non-Hispanic/Latino Unknown</i>				Arab Ethnicity <i>Arab Non-Arab Unknown</i>					
Worksites/School				Occupations/Grade					
Referral Information									
Person Providing Referral									
First		Last		Phone ###-###-####		Ext.		Email	

Case ID	First Name	Last Name	Viral Hepatitis Case Report rev 06/25/2004		Page 2
Referral Information cont.					
Primary Physician					
First	Last	Phone ###-###-####	Ext.	Email	
Street Address					
City	County		State		Zip

Case ID	First Name	Last Name	Viral Hepatitis Case Report rev 06/25/2004		Page 3
Hospital Information					
Patient Hospitalized <div>YesNoUnknown</div>		Hospital		Hospital City	Hospital Record No.
Admission Date <div>mm/dd/yyyy</div>		Discharge Date <div>mm/dd/yyyy</div>		Days Hospitalized	
Clinical Information and Patient History					
Place of Birth: <div>USAOther</div>		Did the patient die from hepatitis? <div>YesNoUnknown</div>		If yes, specify the date of death: <div>mm/dd/yyyy</div>	
Reason for Testing: (Check all that apply) <div><div>Symptoms of acute hepatitis</div><div>Evaluation of elevated liver enzymes</div><div>Screening of asymptomatic patient with reported risk factors</div><div>Blood / Organ donor screening</div><div>Screening of asymptomatic patient with no risk factors (e.g., patient requested)</div><div>Follow-up testing for previous marker of viral hepatitis</div><div>Prenatal screening</div><div>Unknown</div><div>Other</div></div>					
Is the patient symptomatic? <div>YesNoUnknown</div>	Is or was the patient jaundiced? <div>YesNoUnknown</div>	Is or was the patient pregnant? <div>YesNoUnknown</div>		If yes, specify the due or delivery date: <div>mm/dd/yyyy</div>	
Diagnosis: (Check all that apply) <div><div>Acute hepatitis A</div><div>Acute hepatitis B</div><div>Acute hepatitis C</div><div>Acute hepatitis E</div><div>Chronic HBV infection</div><div>HCV infection (chronic or resolved)</div><div>Acute non-ABCD hepatitis</div><div>Perinatal HBV infection</div><div>Hepatitis Delta (co- or super-infection)</div></div>					
Diagnostic Tests					
Test Name				Result	
				P=Positive N=Negative UNK=Unknown	
Total antibody, hepatitis A virus [total anti-HAV]					
IgM antibody to hepatitis A virus [IgM anti-HAV]					
Hepatitis B surface antigen [HBsAg]					
Total antibody, hepatitis B core antigen [Total anti-HBc]					
IgM antibody, hepatitis B core antigen [IgM anti-HBc]					
Antibody to hepatitis D virus [anti-HDV]					
Antibody to hepatitis E virus [anti-HEV]					
Antibody to hepatitis C virus [anti-HCV]					
Supplemental anti-HCV assay [e.g., RIBA]					
HCV RNA [e.g., PCR]					
anti-HCV signal to cut-off ratio					
Liver Enzyme Levels at Time of Diagnosis					
Test Name	Result		Upper Limit Normal		Date of Result
					mm/dd/yyyy
ALT (SGPT)					
AST (SGOT)					

Epidemiologic Information									
Please answer the following questions for the time period 2 weeks - 6 months prior to the onset of symptoms:									
Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?					If yes, type of contact				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Sexual</i> <i>Household (Non-sexual)</i> <i>Other</i> _____				
Did the patient inject drugs not prescribed by a doctor?					Did the patient use street drugs, but not inject?				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Yes</i> <i>No</i> <i>Unknown</i>				
Did the patient undergo hemodialysis?					Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Yes</i> <i>No</i> <i>Unknown</i>				
Did the patient receive blood or blood products (transfusion)?			If yes, when? <small>mm/dd/yyyy</small>		Did the patient receive any IV infusions and/or injections in the outpatient setting?				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Yes</i> <i>No</i> <i>Unknown</i>				
Did the patient have other exposure to someone else's blood?						If yes, specify:			
<i>Yes</i> <i>No</i> <i>Unknown</i>									
Was the patient employed in a medical or dental field involving direct contact with human blood?					If yes, frequency of direct blood contact:				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Frequent (several times weekly)</i> <i>Infrequent</i>				
Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?					If yes, frequency of direct blood contact:				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<i>Frequent (several times weekly)</i> <i>Infrequent</i>				
Did the patient receive a tattoo?			If yes, where was the tattooing performed?						
<i>Yes</i> <i>No</i> <i>Unknown</i>			<small>(Check all that apply)</small> <i>Commercial parlor/shop</i> <i>Correctional facility</i> <i>Other (specify)</i> _____						
Did the patient have any part of their body pierced (other than ear)?			If yes, where was the piercing performed?						
<i>Yes</i> <i>No</i> <i>Unknown</i>			<small>(Check all that apply)</small> <i>Commercial parlor/shop</i> <i>Correctional facility</i> <i>Other (specify)</i> _____						
Did the patient have dental work or oral surgery?			Did the patient have surgery? (other than oral surgery)			Was the patient hospitalized?			
<i>Yes</i> <i>No</i> <i>Unknown</i>			<i>Yes</i> <i>No</i> <i>Unknown</i>			<i>Yes</i> <i>No</i> <i>Unknown</i>			
Was the patient a resident of a long term care facility?									
<i>Yes</i> <i>No</i> <i>Unknown</i>									
Was the patient incarcerated for longer than 24 hours?					If yes, what type of facility?				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<small>(Check all that apply)</small> <i>Prison</i> <i>Jail</i> <i>Juvenile facility</i>				
During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?			If yes, what year was the most recent incarceration?			If yes, for how long?			
<i>Yes</i> <i>No</i> <i>Unknown</i>			<small>yyyy</small>			<small>(months)</small>			
Was the patient EVER treated for a sexually transmitted disease?					If yes, in what year was the most recent treatment?				
<i>Yes</i> <i>No</i> <i>Unknown</i>					<small>yyyy</small>				
In the 6 months prior to symptom onset, how many male sex partners did the patient have?					In the 6 months prior to symptom onset, how many female sex partners did the patient have?				
<i>0</i> <i>1</i> <i>2-5</i> <i>>5</i> <i>Unknown</i>					<i>0</i> <i>1</i> <i>2-5</i> <i>>5</i> <i>Unknown</i>				

[illegible]

Other Information				
Local 1		Local 2		
Name of Person interviewed		Relationship to patient		Date of interview <small>mm/dd/yyyy</small>
Submitted by:	Date <small>mm/dd/yyyy</small>	Health Department	Phone Number <small>###-###-####</small>	Ext.

Other Information cont.

Comments or Additional Information